VERMONT

MEDICAID MANAGED CARE QUALITY STRATEGY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

Produced by
Quality Assurance and Performance Improvement Committee
December 17, 2007

TABLE OF CONTENTS

Introduction

On September 30, 2005, the Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Program. The Global Commitment to Health is a Demonstration Initiative operated under the Section 1115(a) waiver and now encompasses all of Vermont's Medicaid programs with the exception of the Long Term Care Waiver, the State Children's Health Insurance Program and the Disproportionate Hospital Payments. The Legislature gave full approval for participation on the waiver on December 13, 2005.

The Global Commitment Waiver provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g. case rates, capitation, combined funding streams, incentive reimbursements) rather than individual fee-for-service payments, flexibility to pay for healthcare related services not traditionally reimbursable through Medicaid (e.g. pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). It is based on a managed care model which also encourages inter-departmental collaboration and consistency across programs.

Overview

The Federally approved waiver and corresponding changes in Vermont state statute changed the administrative structures of State government to designate the Office of Vermont Health Access (OVHA) as the country's only statewide "public" Managed Care Organization (MCO). The Agency of Human Services (AHS) pays the MCO a lump sum premium payment for the provision of all Medicaid services in the state (apart from the exceptions mentioned above). OVHA will have Intergovernmental Agreements (IGAs) with various AHS Departments to provide programs and services to the Medicaid population. It is believed that the use of a managed care system will allow Vermont to purchase the best value health care for Medicaid beneficiaries, improve access to services for underserved and vulnerable beneficiary populations, and protect them from substandard care. Each state Medicaid agency contracting with a MCO is required to develop and implement a written strategy for assessing and improving the quality of managed care services. The strategy must comply with the provisions issued in the Code of Federal Regulations (CFR).

Structure

The need for AHS-wide cross-departmental operations teams has been identified for at least four core areas. These include Policy, Operations, Fiscal and Quality Assessment and Performance Improvement. Each team is facilitated by an AHS and OVHA senior staff member and/or senior managers from departments and divisions impacted by Global Commitment. These teams are responsible for ensuring that necessary changes in internal operations occur related to the OVHA/MCO work plan, IGA commitments and other relevant state and federal regulations. The Quality Assurance/Performance Improvement Committee (QAPI) is charged with the development, integration, and maintenance of an AHS & OVHA Quality Strategy, generating AHS -wide quality standards for access to care, structure and operations, and quality

measurement and improvement that comply with Title 42 of the Code of Federal Regulations sections 438.206 – 438.236. Additionally, this group will make recommendations to the Secretary's Office regarding the overall AHS direction related to quality and outcome measurement. This Quality Strategy was developed with input from recipients and other stakeholders. Prior to adopting it as final, the Quality Strategy will be made available for public comment. Any feedback will be brought to QAPI for discussion and used to shape the final product. QAPI meets monthly to address any issues regarding compliance. The Quality Strategy supports the authority and responsibility of AHS for the development and implementation of effective management of the Quality Strategy. QAPI is responsible for addressing specific initiatives and/or issues related to the Quality Strategy. AHS is responsible for reporting Quality Strategy activities, findings, and actions. AHS is also responsible for overseeing the work of the External Quality Review (EQR) vendor, and for reviewing and approving the EQR contract deliverables.

Scope

This Quality Strategy sets forth specifications for quality assessment and performance improvement activities that AHS will implement to ensure the delivery of quality health care. It also establishes standards that AHS and the MCO must meet. AHS will conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy as needed. AHS will submit a copy of the initial strategy and a copy of the revised strategy to CMS whenever significant changes are made. Also AHS will submit regular reports on the implementation and effectiveness of the strategy. The following section establishes the scope of work encompassed by the current AHS Quality Strategy program.

- All Medicaid managed care members
- All aspects of care covered by the Global Commitment to Health Waiver
- All aspects of MCO performance.
- All services covered.
- All professional and institutional care in all settings.
- All providers and any other delegated provider type.
- All aspects of MCO internal administrative process related to service and quality of care.

Elements

The Quality Strategy includes, at a minimum, information relating to the following issues:

- OVHA's sub-contract and IGA provisions that incorporate the standards specified in 42 CFR Subpart D
- Procedures that
    - assess and improve the quality and appropriateness of care and services furnished to all Medicaid enrollees through sub-contracts and IGAs especially to individuals with special health care needs
    - identify the race, ethnicity, and primary language spoken of each Medicaid enrollee at the time of enrollment.

  - document how AHS will regularly monitor and evaluate the use of national performance measures and levels that may be identified and developed by CMS in consultation with AHS and other relevant stakeholders.
- Procedures that document how AHS will regularly monitor and evaluate the arrangement for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered.
- Procedures that document how AHS will regularly monitor and evaluate the use of intermediate sanctions.
- Procedures that document how AHS will regularly monitor and evaluate the information system regarding its ability to support initial and ongoing operations and review of the Quality Strategy.
- Procedures that document how AHS will regularly monitor and evaluate compliance with AHS standards for access to care, structure and operations, and quality measurement and improvement.

Purpose

The specific purposes of the Quality Strategy are to:

1. Provide direction and guidance for all staff in the pursuit of the Quality Strategy goals.
2. Provide guidance for determination of activities for the special health care needs populations.
3. Provide guidance to identify race, ethnicity, and primary languages spoken.
4. Assure an information system is in place that will support the efforts of the Quality Strategy.
5. Establish and maintain standards for quality of care, access to care, and quality of service.
6. Verify that services provided to Medicaid recipients conform to professionally recognized standards of practice.
7. Provide Medicaid recipients a means by which they may seek resolutions of perceived failure by providers or personnel to provide appropriate health services, access to care, or quality of care.
8. Establish, maintain, and enforce a policy regarding public review, input, and feedback on Quality Strategy activities.
9. Establish, maintain, and enforce a policy for protection of confidential member and provider information.

Goals

The specific goals of the Quality Strategy are to:

1. Enhance efficiency of care
2. Increase effectiveness of care
3. Promote equity of care
4. Enrich patient-centeredness
5. Ensure safety
6. Improve timeliness of care

Objectives

Results of prior program experience, performance measurement, EQRO, and other quality related reporting activities will help to identify the quality strategy objectives.

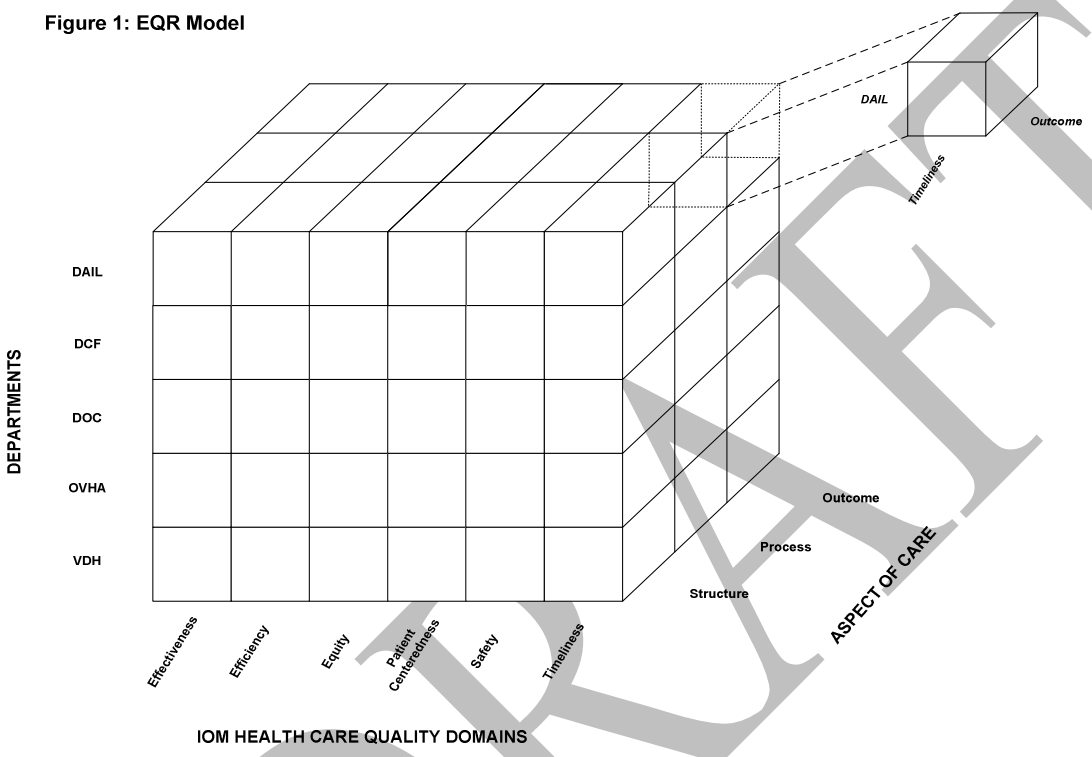
Table 1: Quality Strategy Objectives:

Focus Area	Domain	Aspect	Objective	Time Frame	Targets
Childhood immunization	ET	O	AHS will demonstrate a 10% improvement in childhood immunization rates over the next five years.	10/2005-9/2010	TBD
Adolescent immunization	ET	O	AHS will demonstrate a 10% improvement in adolescent immunization rates over the next five years.	10/2005-9/2010	TBD
Diabetes	ET	O	AHS will demonstrate a 10% improvement in the HgA1c and LDL screening of Medicaid managed care beneficiaries with diabetes over the next five years.	10/2005-9/2010	TBD
Asthma	EF	P	AHS will demonstrate a 5% improvement in the use of appropriate medications for people with asthma over the next five years.	10/2005-9/2010	TBD
Prenatal care	ET	P	AHS will demonstrate a 5% improvement in the rate of pregnant women receiving prenatal care over the next five years.	10/2005-9/2010	TBD
Well-Child visits	ET	P	AHS will demonstrate a 5% improvement in the rate of children receiving well child visits over the next five years.	10/2005-9/2010	TBD
Annual dental visits	EF	S	AHS will demonstrate a 5% improvement in enrollee access to dental visits over the next five years.	10/2005-9/2010	TBD
Behavioral Health	ET	O	AHS will demonstrate a 5% improvement in antidepressant medication management over the next five years.	10/2005-9/2010	TBD
Consumer Satisfaction	PC	O	AHS will demonstrate a 5% improvement in consumers rating of satisfaction with health plan over the next five years.	10/2005-9/2010	TBD

AHS Quality Framework

The Global Commitment waiver will use the EQR (Evaluation of Quality Rubric) evaluative framework depicted in Figure 1 to guide its development, implementation, and evaluation. The EQR Model is a modification of Hammond's EPIC Evaluation Model (Hammond 1973; Fitzpatrick, Sanders, & Worthen 2004), addressing the specific contextual (department), conceptual (IOM Domains), and quality framework (Donabedian's Aspects of Care) inherent to AHS mission and structure. The EQR Model facilitates the operationalization of the department goals and performance objectives, while providing a unified mechanism for assessing factors that influence the success or failure of specific activities inherent at the department-specific level and the larger AHS mission. The EQR Model is efficacious for systems-approached implementations relying in part on process evaluations, as currently conducted by AHS. The model also provides the structure for identification and assessment of the salient outcomes to the objectives of the individual departments. Figure 1 depicts the 90 cells that may be recruited in designing the overall AHS Quality Strategy. A brief definition of each dimension and respective cell components follows.

Figure 1: EQR Model



Domains of Quality

DOMAIN	DEFINITION
Effectiveness (ET)	Providing evidence-based programs/services and care to all who *can* benefit, refraining from providing services that are not of benefit.
Efficiency (EF)	A focus on maximizing resources and minimizing waste – including waste of equipment, supplies, ideas, and energy.
Equity (EQ)	Providing programs/services and care without variation in quality due to gender, ethnicity, geographic location and socioeconomic status.
Patient Centeredness (PC)	Providing programs/services and care that is respectful of and responsive to individual preferences, needs, and values and ensuring that individual values guide all decisions.
Safety (ST)	A focus on avoiding injuries or harm to individuals.
Timeliness (TM)	A focus on obtaining/providing needed programs, services, and care and minimizing unnecessary delays in receiving/providing them.

Aspects of Care

ASPECT	DEFINITION
Structure (S)	Structure elements lay a foundation for quality care by identifying what structures must be in place in a system of care to deliver quality programs/services, and care (e.g. appropriate settings, standards of care, quality standards, staffing policies, etc.).
Process (P)	Process elements build on structure elements and take quality a step further. Process elements identify what interventions must be in place to deliver quality (e.g. care/case management, use of practice guidelines, following standards for interventions, etc.).
Outcome (O)	Outcome elements of quality are the end results of programs/services, and/or care (i.e., enhanced quality).

Focus Areas

The Global Commitment to Health utilizes a multi-faceted approach to improving the care of its Medicaid members through the coordination of programs aimed to address the needs of all Vermonters (i.e., Blueprint, Chronic Care and Disease Management Initiatives, and overall Health Care Reform efforts). Vermont plans to maximize opportunities in the Medicaid managed care system to improve care in the following areas:

- Childhood and Adolescent Immunization
- Chronic Conditions – Asthma and Diabetes
- Prenatal Care
- Children's Health – Well-Child Visits
- Oral Health – Annual Dental Visits
- Behavioral Health
- Consumer Satisfaction

Monitoring and Oversight

This section described how AHS reviews the effectiveness of the quality strategy and revises it accordingly. The Quality Strategy provides a description of AHS's quality program, including standards for safe, effective, quality health care that are required in MCO contracts and the monitoring process, protocols, and strategies AHS uses to ensure compliance with the standards, and a description of how AHS complies with Federal requirements, including external quality review. The Agency of Human Services (AHS) uses two main sources of information to determine compliance with CMS requirements: 1) document review, and 2) interviews with MCO personnel.

Document Review

AHS will monitor MCO compliance with standards using desk audits and an on-site review process. Typically, an onsite visit will begin with a review of documents. Prior to the onsite visit, the MCO will receive a list of documents needed for review. This will be accompanied by instructions on how to organize and prepare the documents for the reviewers. These instructions will request that documents remain available to reviewers for the duration of the onsite visit. Reviewers might request the MCO to provide an orientation to the organization of their documents. Also prior to the onsite visit, reviewers might request reports on previous reviews and subsequent MCO corrective actions in order to identify areas on which the reviewers might need to focus the current monitoring.

During document review, reviewers begin the assessment of compliance with regulatory provisions, and identify issues that will be pursued during interviews. MCO staff does not need to be present during this onsite activity, but should be available if reviewers have questions or difficulty locating a particular document or item of information.

During the review of documentation, reviewers will conduct the following:

- Take notes that will assist in making determinations about compliance with the regulatory provisions;
- Identify topics or issues that need clarification or follow-up during interviews;
- Identify items of information that were not available or located in documents to provide the MCO an opportunity to respond; and
- Identify specific document content for discussion at an interview to provide the MCO an opportunity to prepare participants with copies or to identify additional participants that may be necessary for the discussion.

Interviews

While document review is an important part of determining compliance, understanding the document content and performance of procedures outline in the documents typically can only be determined by talking with MCO personnel. Therefore, interaction with MCO staff is required to obtain a complete picture of the degree of compliance with requirements. Interviews provide clarification. They can reveal the extent to which what is documented is actually implemented.

Interviews also provide an opportunity to explore any issues that were not fully addressed in documents, and also provide a better understanding of MCO performance.

Internal Monitoring

Onsite visits are an effective method for performing monitoring activities such as document review and interviews. Early contact and communication with the MCO is necessary to plan an efficient and effective survey and therefore is a crucial step in arranging and conducting an onsite evaluation. A communication plan and expectations should be outlined and followed to the extent possible. Prior to receiving an onsite visit, the MCO should be provided with information such as: the scope of the evaluation to be performed, how the evaluation will be conducted, lists of documents that need to be available, instructions for the organization and presentation of documents, completion of any forms or other data gathering instruments, expected interview participants, administrative arrangements, and other expectations or responsibilities.

External Oversight

In addition to the internal oversight activities described above, the MCO is required to participate in the annual external independent review of quality outcomes, timeliness of, and access to services covered under this strategy. AHS will contract with an External Quality Review Organization (EQRO) to conduct activities outlined in Subpart E of 42 CFR 438. The EQRO is used to review MCO compliance with AHS specified standards for quality program operations, validation of AHS-required performance measures, and validation of AHS required performance-improvement projects. The external review may include but not be limited to all of any of the following: medical record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, administrative data analysis and review of individual cases. The EQRO will submit a technical report to AHS which will be used to guide quality assessment and improvement efforts. The EQRO report will:

- Assess the MCO's strengths and weaknesses with respect to quality, timeliness and access to health care services
- Provide recommendations for improving quality of programs/services and care furnished by the MCO
- Evaluate the implementation and effectiveness of the Quality Strategy

AHS will be arranging for an EQRO to perform the analysis and evaluation of aggregated information on quality, timeliness, and access to health care services. A contract is expected to be in place November 15, 2007.

Improvement

AHS will assess whether or not the objectives identified in the Introduction have been met by comparing results of performance measures over time. Based on the results of the assessment activities, AHS will attempt to improve the quality of care provided by the MCO. Examples of interventions that might be applied include but are not limited to the following:

- Cross-agency collaborative/initiatives
- Performance improvement projects

- Changes in benefits for program participants
- Information system or electronic health record initiatives
- Implementing optional EQRO activities

In this initial Quality Strategy, AHS will describe the process it intends to follow to embark on quality improvement. As results from the assessment activities are produced, AHS will be able to more clearly define steps to quality improvement.

Achievement and Opportunities

By continuing to monitor the Quality Strategy, AHS will have opportunities to highlight its successes and share what has been found to be effective in improving health care quality and/or service. AHS does not expect all strategy objectives to be met. In these instances, AHS will share the challenges that it encountered and whether the responses to these challenges were effective. Identifying best practices as well as challenges in improving the quality of care for Medicaid beneficiaries might help other states when implementing their own Medicaid managed care programs.

Review of Quality Strategy

AHS will annually review the performance of the Quality Strategy. AHS will report strategy updates to CMS at least annually. The Quality Strategy will use both qualitative and quantitative methods to collect data designed to assess the impact of the Quality Strategy. AHS will use qualitative data such as focus groups and interviews as well as quantitative data from surveys and performance measures to assess performance. Finally, performance measures will be compared with targets to determine impact of Quality Strategy on Quality. As the Quality Strategy evolves, AHS will document challenges and successes that result in changes to the Strategy, including interim performance results as available for each strategy objective.

MCO Standards

The Quality Strategy is organized to reflect the standards outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. AHS Standards are at least as stringent as those specified in 42 CFR 438.200-438.242. Subpart D is divided into three standards: Access, Structure/Operations, and Measurement/Improvement. Each standard has multiple components as indicated in the following table.

STANDARD	REFERENCE	TOPIC
Access	42 CFR 438.206	Availability of services
	42 CFR 438.207	Assurances of adequate capacity and services
	42 CFR 438.208	Coordination and continuity of care
	42 CFR 438.210	Coverage and authorization of services
Structure & Operations	42 CFR 438.214	Provider selection
	42 CFR 438.218	Enrollee information
	42 CFR 438.224	Confidentiality
	42 CFR 438.226	Enrollment and disenrollment
	42 CFR 438.228	Grievance systems
	42 CFR 438.230	Sub contractual relationships and delegation
Measurement & Improvement	42 CFR 438.236	Practice Guidelines
	42 CFR 438.240	Quality assessment and performance improvement program
	42 CFR 438.242	Health information systems

Each of these standards is described in the following sections including methods used to assess compliance with the standards.

Access to Care Standards

This section outlines and discusses the provisions that must be met by the MCO regarding AHS standards for access to care and services, including availability of services; assurances of adequate capacity and services; coordination and continuity of care; and coverage and authorization of services. It also addresses cultural considerations and identification of persons with special care needs.

42 CFR 438.206 Availability of services

These standards ensure that services covered under the Medicaid Plan are available and accessible to enrollees.

MCO requirements

Maintain a Network of Appropriate Providers

Through its contracts with Medicaid providers and subcontracted Departments, the MCO must ensure that a network of appropriate providers is maintained to furnish adequate access to all covered Global Commitment to Health services. In establishing and maintaining this network, the MCO must consider the following:

- Anticipated enrollment in the *Global Commitment to Health Waiver*;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
- That services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- Number and types of providers required to furnish the contracted services;
- Number of providers who are not accepting new patients; and
- Geographic location of providers and *Global Commitment to Health Waiver* enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location(s) provide physical access for enrollees with disabilities.

AHS monitoring activities

AHS has implemented programs and processes to monitor and assure that members' access to care is not restricted. AHS will conduct a thorough analysis of providers to ensure that the MCO is able to provide access to health care services as required. AHS will review the MCO Provider and geographic access data to determine compliance with this standard. The Provider Capacity data will contain information on the number and type of providers, anticipated enrollment, and actual and expected health care utilization. In addition to identifying the number of providers available by specialty and type, this data will also contain the number of PCPs and mental health practitioners accepting new Medicaid patients, as well as, those not accepting new Medicaid patients. Geographic access data will contain the geographic distribution of each primary, specialty, and behavioral health care provider. Focus of the review will be on access to services (e.g., calculated distance for members to travel from their primary residence to PCPs, specialists, hospitals, etc., 24-hour availability of services, scheduling and wait times, types of transportation that members ordinarily use for each service area, number of providers with physical access for members with disabilities for each service area, and selection and assignment of primary care provider). By monitoring this data, AHS will ensure that there are sufficient numbers and types of health care resources available to Medicaid enrollees. In addition to the above, AHS will conduct the following activities:

* Review provider directory annually (including volume of non-Medicaid individuals served)
* Review the MCO's provider contracts and contracting and non-contracting provider selection criteria
* Review results of MCO provider and/or enrollee survey re: geographic accessibility and physical accessibility of care

Provides Beneficiaries with Direct Access to a Women's Health Specialist:

MCO requirements

The MCO must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

AHS Monitoring Activities

AHS will ensure that the MCO stipulates direct access to a women's health specialist by conducting the following activities:

* Review new enrollee materials or enrollee handbook
* Review provider directory no less than biennially (identifying women's health specialist)

Cultural Considerations

MCO requirements

The MCO shall participate in AHS efforts to promote the delivery of services in a culturally competent manner to all *Global Commitment to Health Waiver* enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO shall comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. The MCO shall develop appropriate methods of communicating with its enrollees who do not speak English as a first language, as well as, enrollees who are visually and hearing impaired, and accommodating enrollees with physical disabilities and different learning styles and capabilities. Enrollee materials, including the enrollee handbook, shall be made available in all prevalent non-English languages. A prevalent non-English language shall mean any language spoken as a first language by five percent or more of the total statewide Global Commitment to Health Waiver enrollment.

The MCO shall ensure in-person or telephonic interpreter services are available to any enrollee who requests them, regardless of the prevalence of the enrollee's language within the overall program. AHS contracts with in-person and telephonic interpreter vendors, as well as, written translation vendors on behalf of OVHA and other departments under the AHS umbrella. The MCO will use these vendors as necessary and will bear the cost of their services, as well as the costs associated with making American Sign Language (ASL) interpreters and Braille materials available to hearing- and vision-impaired enrollees.

OVHA shall include information in the enrollee handbook on the availability of oral interpreter services, translated written materials, and materials in alternative formats. The Global Commitment to Health enrollee handbook shall also include information on how to access such services.

AHS Monitoring Activities

AHS will assess the cultural, ethnic, racial and linguistic needs of Medicaid beneficiaries and make recommendations to the MCO to adjust the availability of practitioners within its network, if necessary. AHS will review IGAs to ensure that they stipulate culturally and linguistically appropriate care to members. AHS will also review new member materials, the enrollee handbook, and provider contracts to ensure compliance with this standard.

Provides for a Second Opinion from a Qualified Health Professional

> The MCO must provide for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one, at no cost to the enrollee.
> **(4)** If the network is unable to provide necessary medical services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee for as long as the MCO is unable to provide them.
> **(5)** Requires out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

Global Commitment to Health enrollees served through the public insurance programs shall have the right to obtain a second opinion from a qualified health care professional, within the network of enrolled Medicaid providers. If needed, the MCO will arrange for the enrollee to obtain a second opinion by enrolling a qualified provider in the program, at no cost to the enrollee.

AHS Monitoring Activities

AHS will review IGAs to ensure that they provide for a second opinion from a qualified health professional. In addition, AHS shall conduct the following activities:

* Review provider agreements
* Review new member materials and enrollee handbooks

Provides Services Not Available In-Network:
If the network is unable to provide necessary services covered under the MCO contract to a particular beneficiary, OVHA must adequately and timely cover these services out-of-network for the beneficiary, for as long as the MCO is unable to provide the coverage.

AHS Monitoring Activities

AHS will review IGAs to ensure that they provide for services that are not available. In addition, AHS will conduct the following activities:

* Review the MCO's new member materials, enrollee handbooks, and other enrollee information materials

Coordination of Payment with Out-of-Network Providers:
N/A

Demonstrates Providers are Credentialed:

The MCO must demonstrate that its providers are credentialed

The MCO shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the credentialing requirements established by AHS for the Medicaid program. At a minimum, the MCO shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

AHS Monitoring Activities

AHS ensures compliance with these standards through review of provider contracts and survey data. To provide further assurance of compliance, AHS may also crosscheck a sample of executed provider agreements with the National Practitioner Data Bank for sanctions or licensure limitations.

Timely Access to Services:

The MCO must comply with the requirements of this paragraph. **(1)** ***Timely access.*** The MCO must-- **(i)** Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services; **(ii)** Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. **(iii)** Makes services available 24 hours a day, 7 days a week when medically necessary. **(iv)** Establish mechanisms to ensure compliance. **(v)** Monitor providers regularly to determine compliance. **(vi)** Take corrective action if there is a failure to comply.

In addition to delivery system structure and organization, timeliness of services is central to provision of accessible care. The MCO must ensure that coverage is available to enrollees on a twenty-four hour per day, seven day per week basis. Coverage may be delegated to the subcontracted Departments, but the MCO must maintain procedures for monitoring coverage to ensure twenty-four hour availability.

The MCO shall ensure that travel time to services does not exceed the limits described below:

Primary Care – No more than 30 miles or 30 minutes for all enrollees from residence or place of business unless the usual and customary standard in an area is greater, due to an absence of providers. The MCO's network will include all Medicaid participating providers, which equates to nearly all providers in the State of Vermont. However, if the travel time standard is exceeded in an area which contains a non-participating provider, the MCO will work aggressively to bring that provider into the network.

Hospitals – Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater, mental health services where access to specialty care may require longer transport time, and for physical rehabilitative services where access is not to exceed 60 minutes.

General Optometry – Transport time will be the usual and customary, not to exceed one hour, except in areas where community standards will apply.

Lab and X-Ray – Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards will apply.

All Other Services – All services not specified above shall meet the usual and customary standards for the community.

The MCO shall require its providers to meet in-office waiting times for appointments do not exceed one hour, except in areas where a longer waiting time is usual and customary. Exceptions to the one-hour standards must be justified and documented to AHS on the basis of community standards.

Appointment availability shall meet the usual and customary standards for the community, and shall comply with the following:

- Urgent care: Within twenty-four hours;
- Non-urgent, non-emergent conditions: Within 14 days;
- Preventive Care: Within 90 days.

Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

The MCO must establish mechanisms to ensure that network providers comply with the timely access requirements; monitor regularly to determine compliance; and take corrective action if there is a failure to comply.

AHS Monitoring Activities

AHS will review data regarding regular and routine care appointments, urgent care appointments, and after-hours care. AHS monitors this data to assure that there will be providers within the standards for distance and travel time. AHS will accomplish the above by conducting the following activities:

* Review survey data from enrollees/providers
* Review provider contracts, orientation, or enrollment documents
* Review new member materials, enrollee handbooks
* Review Grievance/Appeal data

42 CFR 438.207 Assurance of adequate capacity and services

MCO Requirements

The MCO shall update network capacity data biennially and at any time there has been a significant change in the MCO's operations that would affect adequate capacity or services, including changes in services, benefits, payments or enrollment of a new population.

AHS Monitoring Activities

AHS shall review variable definitions used by the MCO to provide network capacity data. This activity will assess whether or not the MCO offers an appropriate range of covered services adequate for the anticipated number of enrollees for the service and that the MCO maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

42 CFR 438.208 Coordination and continuity of care

MCO Requirements

The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees. These procedures must meet State requirements and must do the following:

(1) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(2) Coordinate the services the MCO furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

(3) Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.

(4) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) ***Additional services for enrollees with special health care needs.***

(1) Identification. The State must implement mechanisms to identify persons with special health care needs to the MCO, as those persons are defined by the State. These identification mechanisms must—

(i) Must be specified in the State's quality improvement strategy in § 438.202; and

(ii) May use State staff, the State's enrollment broker, or the State's MCOs and PIHPs.

438.208 Coordination and continuity of care – *continued*

(2) Assessment. The MCO must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

(3) Treatment plans. If the State requires MCO to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

(i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

(ii) Approved by the MCO in a timely manner, if this approval is required by the MCO; and

(iii) In accord with any applicable State quality assurance and utilization review standards.

(4) Direct access to specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with § 438.208(c)(2)) to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Modern health care delivery systems are multi-faceted and involve complex interactions between many providers. Such delivery systems require coordination across the continuum of care. This standard requires that the MCO implement procedures to deliver primary care to and coordinate health care services for all enrollees.

The MCO shall assist in the coordination of services provided through its network of Medicaid providers and its subcontracted Departments. The MCO shall require that each enrollee's record contains the name of his/her primary care provider.

The MCO shall maintain mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. When treatment plans are required, the treatment plan must be developed with the participation of the enrollees' primary care provider and enrollee, in consultation with any specialists caring for the enrollee. The treatment plan must be approved by the MCO in a timely manner, if approval is required. The treatment plan must conform to the State's quality assurance and utilization review standards.

If the contracted network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them.

Primary care coordination

The MCO must ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care delivered to the enrollee. All members shall select their PCP, but if the member does not select a PCP, the MCO must select one for the member and notify the member of the PCP's name, location, and office telephone number.

Members with special health care needs

The MCO is required to establish and maintain policies and procedures to identify and coordinate health care services for members with special health care needs (e.g., mental health and substance abuse, TBI, developmental disabilities, children with special health care needs, etc.). For each enrollee that the managed care entity confirms as having special health care needs, the individual is assigned a care coordinator. In addition to facilitating the development of a multidisciplinary service plan, the care coordinator is also responsible for coordinating service among providers, monitoring the treatment plan, and providing periodic reassessments.

The MCO defines individuals with special health care needs and is able to identify such enrollees through information contained in Health Risk Assessments; special application for service (e.g., DS, CMH, TBI, etc.), claims data review, or any other available data source.

AHS Monitoring Activities

In accordance with 42 CFR 438.208, the MCO with its sub-contractors must implement procedures to deliver primary care and coordinate health care for all beneficiaries. AHS looks for three elements to determine if the MCO has a basic system in existence: (1) beneficiaries with special health care needs must receive case management services according to established criteria and must receive the appropriate care; (2) the MCO must have IGAs with other appropriate agencies or institutions to coordinate care; and (3) the MCO must monitor continuity of care across all services and treatment modalities. AHS will review the following documents to determine compliance with this standard:

* New member materials, enrollee handbooks
* Provider manuals and contracts
* Agreements between OVHA and its IGA partners

42 CFR 438.210 Coverage and authorization of services

MCO Requirements

Coverage

The Global Commitment to Health Waiver includes a comprehensive health care services benefit package. The covered services will include all services that AHS requires be made available through its public insurance programs to enrollees in the Global Commitment to Health Waiver including all State of Vermont title XIX plan services in the following categories:

- Acute health care services
- Preventive health services
- Behavioral health services, including substance abuse treatment
- Specialized mental health services for adults and children
- Developmental services
- Pharmacy services
- School-based services

The monthly capitation amount paid by AHS to OVHA, as the Public MCO, will include payment only for services covered under the Global commitment to Health Waiver.

Authorization of Services

For the processing of requests for initial and continuing authorizations of services, each contract must require--

(1) That the MCO and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO --

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

The term "service authorization request" means a Global Commitment to Health Waiver enrollee's request for the provision of a service, or a request by the enrollee's provider.

OVHA and its IGA partners shall maintain and follow written policies and procedures for processing requests for initial and continuing authorization of medically necessary, covered services. The policies and procedures must conform to all applicable Federal and State regulations, including specifically 42 CFR 438.210(b).

OVHA may require pre-authorization for certain covered services including, but not limited to, inpatient hospital admissions, home and community based services, and certain pharmaceutical products. For inpatient admissions, specific review criteria for authorization decisions is identified and outlined in the Acute Care Management Program Descriptions policies and procedures manual. OVHA will ensure consistent application of review criteria for authorization decisions. Review Criteria shall be incorporated in the Utilization Management Plan.

For standard authorization decisions, the subcontracted Departments must reach a decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 14 calendar days from receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or the subcontracted Department justifies to OVHA a need for additional information and how the extension is in the enrollee's best interest.

For cases in which a provider indicates, or the subcontracted Department determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, the subcontracted Department must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service. The three days may be extended by up to 14 additional calendar days if the enrollee requests the extension, or if the subcontracted Department justifies to OVHA a need for additional information and how the extension is in the enrollee's interest.

Any case where a decision is not reached within the referenced timeframes constitutes a denial. Written notice must then be issued to the enrollee on the date that the timeframe for the authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.

Planned services will be identified by the authorized clinician working with the enrollee and under the direct supervision of a prescribing provider. Any decision to deny, reduce the range, or suspend covered services, or a failure to approve a service that requires pre-authorization, will constitute grounds for noticing the enrollee. Any disagreement identified by the enrollee at any interval of evaluation, will also be subject to notice requirements.

Notices must meet language format requirements set in the above section.

Notice must be given within the timeframes set forth above, except that notice may be given on the date of action under the following circumstances:

- Signed written enrollee statement requesting service termination;
- Signed written enrollee statement requesting new service or range increase:

- An enrollee's admission to an institution where he or she is ineligible for further services;
- An enrollee's address is unknown and mail directed to him or her has no forwarding address;
- The enrollee's physician prescribes the change in the range of clinical need

OVHA or its IGA partner shall notify the requesting provider and issue written notices to enrollees for any decision to deny a service, or to authorize a service in an amount, scope or duration less than that requested and clinically prescribed in the service plan. Notices must explain the action OVHA or the IGA partner has taken or intends to take; the reasons for the action; the enrollee's right to a second opinion regarding the service decision, or at least, a clinical program director not involved in the service decision; the enrollee's right to file an appeal and procedures for doing so; circumstances under which an expedited resolution is available and how to request one; the enrollee's right at any time to request a Fair Hearing for covered services and how to request that covered services be extended; the enrollee's right to request external review by OVHA/AHS for covered services (as applicable to Medicaid eligibility) or alternate services; and the circumstances under which the enrollee may be required to pay the costs of those services pending the outcome of a Fair Hearing or external review by OVHA/AHS.

AHS Monitoring Activities

AHS will review MCO policies/procedures requiring licensed professionals to supervise all medical necessity decisions as well as written procedures specifying the type of personnel responsible for each level of UM decision making. In addition, AHS might also review written job descriptions with qualifications for practitioners who review denials of care based on medical necessity that requires: education, training or professional experience in medical or clinical practice and current license to practice without restriction. In addition, AHS shall conduct the following activities:

* Review OVHA/IGA Partner provider manuals

* Review grievance files or aggregate data related to payment/non-payment for services.

* Review the MCO's agreements with employees who perform utilization management activities.

Structural and Operational Standards

This section outlines and discusses the contract provisions that must be met by the MCO regarding AHS standards for structure and operations including provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems, and subcontractual relationships and delegation.

42 CFR 438.214 Provider selection

MCO Requirements

In accordance with 42 CFR 438.214, the MCO must implement written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, a process contracting with providers who have signed contracts or participation agreements with the MCO, that these policies and procedures and they do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. In addition, the MCO may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. Finally, the MCO must comply with the additional requirements established by the State listed below:

The MCO shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the requirements established by AHS for the Medicaid program. At a minimum, the MCO shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

The MCO agrees to ensure that network providers do not intentionally discriminate against *Global Commitment to Health Waiver* enrollees in the acceptance of patients into provider panels, or intentionally segregate Global Commitment to Health enrollees in any way from other individuals receiving services.

The MCO shall not knowingly have a relationship with either of the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

AHS Monitoring Activities

AHS will review a sample of provider files and provider contract to determine the extent to which the standards are being implemented. In addition, AHS will review aggregate information and individual files of a sample of provider for whom the MCO has recently denied participation.

42 CFR 438.218 Enrollee information

MCO Requirements

The MCO shall be responsible for educating individuals at the time of their enrollment into the *Global Commitment to Health Waiver*. Education activities may be conducted via mail, by telephone and/or through face-to-face meetings. The MCO may employ the services of an enrollment broker to assist in outreach and education activities.

The MCO shall provide information and assist enrollees in understanding all facets pertinent to their enrollment, including the following:

- What services are covered and how to access them
- Restrictions on freedom-of-choice
- Cost sharing
- Role and responsibilities of the primary care provider (PCP)
- Importance of selecting and building a relationship with a PCP
- Information about how to access a list of PCPs in geographic proximity to the enrollee and the availability of a complete network roster
- Enrollee rights, including appeal and Fair Hearing rights (described in greater detail below); confidentiality rights; availability of the Office of Health Care Ombudsman; and enrollee-initiated dis-enrollment
- Enrollee responsibilities, including making, keeping, canceling appointments with PCPs and specialists; necessity of obtaining prior authorization (PA) for certain services and proper utilization of the emergency room (ER)

The MCO and AHS shall coordinate the development of the *Global Commitment to Health Waiver* enrollee handbook, which shall help enrollees and potential enrollees understand the requirements and benefits of the various programs available through the *Global Commitment to Health Waiver*. The MCO shall mail the enrollee handbook to all new enrollee households within 45 business days of determination of eligibility for the *Global Commitment to Health Waiver*. Enrollees may request and obtain an enrollee handbook at any time.

The enrollee handbook must be specific to the *Global Commitment to Health Waiver* and be written in language that is clear and easily understood by an elementary-level reader. The enrollee handbook must include a comprehensive description of the *Global Commitment to Health Waiver*, including a description of covered benefits, how to access services in urgent and emergent situations, how to access services in other situations (including family planning services and providers not participating in the Vermont Medicaid program), complaint and grievance procedures, appeal procedures (for eligibility determinations or service denials), enrollee disenrollment rights, and advance directives.

With respect to information on grievance, appeal and Fair Hearing procedures and timeframes, the *Global Commitment to Health Waiver* enrollee handbook must include the following information:

- Right to a State of Vermont Fair Hearing, method for obtaining a hearing, timeframe for filing a request, timeframes for resolution of the Fair Hearing, and rules that govern representation at the hearing;
- Right to file grievances and appeals;
- Requirements and timeframes for filing a grievance or appeal;
- Availability of assistance in the filing process;
- Toll-free numbers that the enrollee can use to obtain assistance in filing a grievance or an appeal;
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for a State of Vermont Fair Hearing within the timeframes specified for filing; and that the enrollee may be required to pay the cost of any services furnished while the appeal is pending if the denial is upheld;
- Any appeal rights that the State of Vermont makes available to providers to challenge the failure of the MCO to cover a service;
- Information about Advance Directives and the service providers' obligation to honor the terms of such directives;

The following additional information must be included in the enrollee handbook:

- Information on specialty referrals;
- Information on accessing emergent and urgent care (including post-stabilization services and after-hours care);

- Information on enrollee disenrollment;
- Information on enrollee right to change providers;
- Information on restrictions to freedom of choice among network providers;
- Information on enrollee rights and protections, as specified in 42 CFR 438.100 and IGA Section 2.15;
- Information on enrollee cost sharing; and
- Additional information that is available upon request, including information on the structure of the *Global Commitment to Health Waiver* and any physician incentive plans.

  The MCO shall notify its enrollees in writing of any change that AHS defines as significant to the information in the *Global Commitment to Health Waiver* enrollee handbook at least 30 business days before the intended effective date of the change.

AHS Monitoring Activities

AHS will review Enrollee Handbook annually, as well as, welcome packet and any updates as needed.

Confidentiality

The MCO agrees that all information, records, and data collected with the agreement shall be protected from unauthorized disclosures. In accordance with section 1902(a)(7) of the Social Security Act, the MCO agrees to provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. In addition, the MCO agrees to guard the confidentiality of recipient information, in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164. Access to recipient identifying information shall be limited by the MCO to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including AHS, the United States DHHS, and other individuals or entities as may be required by the State of Vermont.

Any other party may be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations, including 42 CFR 431, Subpart F pertaining to such access. AHS shall have absolute authority to determine if and when any other party shall have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

Nothing in this section shall be construed to limit or deny access by enrollees or their duly authorized representatives to medical records or information compiled regarding their case, or coverage, treatment or other relevant determinations regarding their care, as mandated by State and/or Federal laws and regulations.

AHS Monitoring Activities

AHS will review provider contracts and partner IGAs for policies and procedures regarding the use and disclosure of any individually identifiable health information.

42 CFR 438.226 Enrollment and disenrollment

MCO Requirements

The MCO must comply with the enrollment and disenrollment requirements and limitations set forth in 438.56 including; disenrollment requested by the MCO, disenrollment requested by the enrollee, procedures for disenrollment, and timeframes for disenrollment determinations. The MCO shall ensure that individuals who lose eligibility are disenrolled from the *Global Commitment to Health Waiver*. Loss of eligibility may occur due to:

- Death;
- Movement out of State of Vermont;
- Incarceration;
- No longer meeting the eligibility requirements for medical assistance under the *Global Commitment to Health Waiver*; and
- The enrollee's request to have his/her eligibility terminated and to be disenrolled from the program

The MCO shall compare, on a daily and no less than monthly basis, the active Global Commitment to Health enrollee list with the ESD's Medicaid/VHAP eligibility list to confirm Medicaid/VHAP status for all Global Commitment to Health enrollees. OVHA shall not receive a capitation payment for any individual who is not eligible under the *Global Commitment to Health Waiver*.

The MCO shall not disenroll any individual except those who have lost eligibility as specified under 2.2.4 of the AHS/OVHA IGA. This prohibition specifically precludes disenrollment on the basis of an adverse change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

AHS Monitoring Activities

AHS will review ESD policies and procedures pertaining to enrollment. Upon request, information on dis-enrollments (by reason code) shall be available to AHS for audit purposes.

42 CFR 438.228 Grievance System

MCO Requirements

The MCO must have a grievance system that meets the requirements of CFR 438 Subpart F. OVHA and its IGA partners shall adhere to uniform Grievance and Appeals rules and policies. AHS shall be responsible for ensuring grievance and appeals rules, policies and practices comply with the federal statutes and regulations, including provisions applicable to MCO operations. For purposes of the Grievance and Appeals process, Designated Agencies and Specialized Services Agencies are contracted agents of the MCO. Therefore, any decisions these entities make that fall under the definition of "action" as defined at 42 CFR 438.400 are subject to the MCO's appeal process. The MCOs must maintain records of grievances and appeals. Grievance is defined as an expression of dissatisfaction about any matter other than an "action." An appeal is defined as a request for review of an "action."

Action is defined to include:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of an MCO to act within the timeframes; or
- Denial of a Medicaid enrollee's request to obtain services outside the network:
  - from any other provider (in terms of training, experience, and specialization) not available within the network
  - from a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
  - Because the only plan or provider available does not provide the service because of moral or religious objections.
  - Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
  - The State determines that other circumstances warrant out-of-network treatment.

AHS Monitoring Activities

The Agency of Human Services (AHS) shall engage in various activities to ensure the following two requirements are met:

- the Managed Care Organization (MCO) has in effect a grievance system that meets the requirements of 42 CFR Part 438 Subpart F, and
- the MCO operations related to the processing of grievances and appeals are monitored as specified in 42 CFR 438.66.

First, AHS shall require that the MCO submit on a quarterly basis a Grievance and Appeal Activity Report. This report shall contain aggregate information regarding the number, type, origin, notification and resolution time, and decision of each activity; a list of all grievances that have not been resolved to the satisfaction of the enrollee; the nature of grievances requiring expedited review and the decisions; and any trends relating to a particular provider or service. If the report reveals "undesirable trends" relating to a particular provider or service, the MCO must conduct an in-depth review, report the findings to AHS, and take corrective action. Second, Grievance and Appeal Activity Reports shall be presented quarterly to the Agency Quality Assurance and Performance Improvement (QAPI) Committee for identification of patterns or trends that might emerge and to identify areas on which to focus improvement efforts. Finally, AHS or its designee shall annually review a random sample of all grievance and appeal files to ensure that they comply with all applicable AHS standards identified in the Quality Strategy as well as all Federal standards contained in 42 CFR Part 438 Subpart F and 42 CFR 438.210(c). Standards include but are not limited to the following:

- Notice of action
- Resolution and notification
- Expedited resolution of appeals
- Information about the grievance system to providers and subcontractors
- Continuation of benefits
- Effectuation of reversed appeal resolutions

<u>42 CFR 438.230 Subcontractual relationships and delegation</u>

MCO Requirements

The MCO may subcontract with other State Departments under the AHS umbrella to provide certain covered *Global Commitment to Health Waiver* services that are relevant to the programs they administer, including the Department for Disabilities, Aging and Independent Living (DAIL), Department of Health (VDH), Department of Education (DOE), Department of Mental Health (DMH), and the Department for Children and Families (DCF) – (collectively referred to as the Departments). Prior to subcontracting with any other entity, OVHA shall evaluate each Department's ability to perform the activities covered under the proposed contract.

In addition to services available through the subcontracted Departments, enrollees may access certain health and mental health services from licensed Medicaid-enrolled providers.

Licensed and enrolled Medicaid providers must:

- Meet the requirements set forth in 42 CFR 431.107;
- Meet OVHA's established enrollment requirements;
- Be willing to coordinate care with OVHA or its designee, including sharing clinical information (with appropriate enrollee consent); and

- Accept OVHA's fee schedule.

Unless authorized by State or federal statute or regulation, the MCO and the subcontracted Departments shall be prohibited from discriminating with respect to the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State of Vermont law, solely on the basis of that license or certification. This provision does not prohibit the MCO and the subcontracted Departments from limiting network participation based on quality, cost or other reasonable business purposes as permitted under federal laws and regulations. If a provider is denied enrollment in the Medicaid program the MCO must provide written notice of its reason(s) for denying enrollment.

All contracts and subcontracts for services pertinent to the *Global Commitment to Health Waiver* must be in writing and must provide that AHS and the United States Department of Health and Human Services (DHHS) may:

- Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and
- Inspect and audit any financial records of such contractor/subcontractor.

Written contracts must specify the activities and reporting responsibilities of the contractor or subcontractor and provide for revoking delegation or imposing other sanctions if the contractor or subcontractor's performance is inadequate.

No subcontract terminates the responsibility of AHS and the MCO to ensure that all activities under this IGA are carried out. In the event of non-compliance, AHS (as the Single State Agency) will determine the appropriate course of action to ensure compliance. The MCO agrees to make available to AHS and CMS all subcontracts between the MCO and the Departments.

The MCO shall maintain evaluation tools, reports, improvement plans, and reported service data profiles used in the service plan and utilization review monitoring activity. At the direction of AHS, the MCO shall also conduct ongoing monitoring of the Departmental subcontractors through the review of required reports and data submissions.

AHS Monitoring Activities

AHS will perform the following activities to ensure compliance with the aforementioned standard:
* Review sample of MCO contracts or written agreements with entities performing the delegated activities
* Review results of the most recent review of the delegated activity

MEASUREMENT AND IMPROVEMENT STANDARDS

This section of the Quality Strategy outlines and discusses standards for performance measurement and improvement systems.

42 CFR 438.236 Practice guidelines

MCO Requirements

Practice Guidelines

The MCO shall adopt program guidelines that are based on valid clinical evidence, or based on the consensus of health care professionals, consideration of the needs of enrollees, and consultation with health care professionals who participate in the Global Commitment to Health Waiver and other program stakeholders. Program guidelines shall be reviewed and updated periodically as appropriate. The MCO shall disseminate the guidelines to its subcontracted Departments and shall require the Departments to disseminate the guidelines among all their designated providers.

AHS Monitoring Activities

The MCO must provide evidence that they have adopted clinical practice guidelines for the treatment of at least two acute or chronic health conditions. AHS shall review the following:
* Practice guidelines
* Provider manuals, enrollee handbook, newsletters, bulletins or other forms of communication for evidence of use of practice guidelines

42 CFR 438.240 Quality Assessment and Performance Improvement Program

MCO Requirements

The MCO shall maintain a comprehensive Quality Plan for the Global Commitment to Health Waiver that details the plans, tasks, initiatives, and staff responsible for improving quality and meeting the requirements and beneficiary services incorporated under the MCO contract. All IGA partners must also develop and maintain an internal Quality Plan. In addition to complying with contractual terms related to specific CQI activities, processes and reporting, the MCO must have procedures that: (1) assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs; (2) detect the over-utilization and under-utilization of health care services; (3) regularly monitor and evaluate compliance with the standards for MCOs, and (4) comply with any national performance measures and levels that may be identified and developed by the Center for Medicare and Medicaid Services (CMS) in consultation with AHS and other relevant stakeholders. The Quality Management Plan shall conform to all applicable Federal and State regulations. The Quality Management Plan shall be available to AHS upon request.

The MCO is required to report Performance Measures including results from Consumer Satisfaction Feedback Activities to AHS to assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs. Performance Measures will be required in the following focus areas:

- Childhood and Adolescent Immunization
- Chronic Conditions – Asthma and Diabetes

- Prenatal Care
- Children's Health – Well-Child Visits
- Oral Health – Annual Dental Visits
- Behavioral Health
- Consumer Satisfaction

The MCO will report Performance Measurement data to AHS on a quarterly basis. The MCO is required to track and trend this data to watch for any patterns. A corrective action report will be required after 3 quarters of a negative trend. The MCO might include plans for a Performance Improvement Projects when the agreed upon indicators is below the performance rate previously defined. Possible Performance measures could include:

- HEDIS clinical measure
- HEDIS-like clinical measure
- CAHPS composite, rating result or question
- Non-CAHPS composite, rating result or question in an area of service identified as relevant to the MCO's enrollees.

The MCO must also conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services that are expected to have a favorable effect on health outcomes and member satisfaction. The performance improvement projects should focus on clinical and non-clinical areas, and involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvements in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting of the status and results of each project to AHS as requested in a timely manner.

Each year the MCO must select one focus area in which to conduct a quality improvement project. These projects may take several years to complete but must demonstrate sustained improvement as required in the CMS protocol. Proposed projects will be submitted to AHS for review and approval assuring the project meets the following criteria:

- Evaluates the quality (i.e., effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness) of programs/services and care
- Has a favorable effect on the structure, process, or outcome of programs/services and/or care
- Uses indicators of quality that are objective performance measures (i.e., use of measures and metrics),
- Increases or sustains the improvements obtained.

The CMS or AHS may specify performance measures and topics for performance improvement projects.

The MCO shall also develop and maintain a comprehensive Utilization Management Plan to identify potential over- and under-utilization of services. The Utilization Management Plan must

conform to all applicable Federal and State regulations. The MCO shall not structure compensation for any entity that conducts utilization management services in such a way to provide incentives for the denial, limitation or discontinuation of medically necessary services to any enrollee.

AHS Monitoring Activities

AHS will annually review the MCO's Quality Plan, including practitioner availability and accessibility, clinical practice guidelines, continuity and coordination of care, clinical and non-clinical performance measures, and performance improvement activities. Review of the quality program includes use of preventive health guidelines and disease management programs, care coordination or case management programs to enrollees and practitioners. Other standards reviewed include: utilization management, information systems, medical record documentation standards and confidentiality policies and procedures.

AHS will monitor results of performance measures (including feedback from enrollees) and other methodologies to monitor services provided to Vermont Medicaid members annually. In addition to consumer satisfaction surveys, AHS will also monitor member perceptions of accessibility and adequacy of services through the use of anecdotal information, grievance and appeals data, and enrollment information. Audits of the performance measures are followed by corrective action plans when appropriate. OVHA and its sub-contracts are also required to report the status and results of each performance improvement project in an annual report and upon request of AHS. In addition to the above, AHS will perform the following activities:
* Review data gathered as a result of compliance monitoring activities
*Conduct compliance monitoring of QAPI Standards
*Review data for evidence that claims are evaluated to assess the degree of over-and under-utilization

<u>42 CFR 438.242 Health Information Systems</u>

MCO Requirements

In accordance with 42 CFR 438.242, the MCO shall maintain a management information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The system must collect data on enrollee and provider characteristics. The MCO management information system must have the capabilities to collect, maintain, and report encounter data in accordance with the Global Commitment to Health Waiver's Terms and Conditions. All collected data must be available to AHS and the CMS upon request.

The MCO must also maintain claims history data for all Global Commitment to Health Waiver enrollees through contractual arrangements with its Fiscal Agent. IGA partners shall submit encounter reports for all services rendered to Global Commitment to Health Waiver enrollees, when service-specific claims for such services are not processed through the MMIS. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid

Waiver Demonstration. The MCO must make such claims and encounter data available to AHS and CMS upon request.

Encounter data submitted to OVHA and IGA partners will be edited by OVHA and IGA partners for accuracy, timeliness, correctness, and completeness. Any encounter data failing edits will be deleted. Any encounter data denied will be returned to the provider for review and possible resubmission. Encounter data must represent services provided to Global Commitment to Health Waiver enrollees only. The MCO must have a process to ensure that services were actually provided. In addition to the automated process described above, the MCO will at least biennially perform medical/case record reviews for the purposes of comparing submitted claims and encounter data to the medical record to assess correctness, completeness and to review for omissions in encounters or claims.

While there is currently an information system that supports initial and ongoing operation and review of the Quality Strategy, AHS in collaboration with the MCO and its IGA partners is currently developing a data ware house that will be able to provide encounter (i.e., aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities). This evolving Health Information Technology will impact the future monitoring of QAPI activities.

AHS Monitoring Activities

AHS shall have access to the claims and encounter data as reported by OVHA or its IGA partner. AHS will monitor MCO encounter and claims data procedures in order to ensure compliance with this standard. Monitoring includes the following activities:
* Review procedures used by the MCO to ensure the reliability of the data obtained from the providers and contained in it MIS
* Review reports produced by the MIS to support utilization management, grievance processes, enrollment services, and its QAPI program
* Review provider contracts to determine the extent to which expectations for data collection and reporting are outlined